Authorization for Release of Patient Health Information and Records

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Cottonwood Pediatrics

PARENT FULL NAME: _____ PHONE #: _____

CHILD 1: _____ (FIRST NAME) _____ (MI) _____ (LAST NAME) _____ / / (DATE OF BIRTH)

CHILD 2: _____ (FIRST NAME) _____ (MI) _____ (LAST NAME) _____ / / (DATE OF BIRTH)

CHILD 3: _____ (FIRST NAME) _____ (MI) _____ (LAST NAME) _____ / / (DATE OF BIRTH)

CHILD 4: _____ (FIRST NAME) _____ (MI) _____ (LAST NAME) _____ / / (DATE OF BIRTH)

I AUTHORIZE COTTONWOD PEDIATRICS TO

☐ disclose information to ☐ request information from ☐ exchange information with (obtain and/or disclose)

_____ (ORGANIZATION (or person name & relationship to patient)) _____ (PHONE #) _____ (FAX#)

_____ (STREET ADDRESS) _____ (CITY, STATE, ZIP)

PURPOSE OR NEED FOR THIS INFORMATION

TRANSFERING: ☐ age 18 & over ☐ moving ☐ leaving practice

NOT TRANSFERING: ☐ continuing care ☐ specialist use ☐ copies for own use ($20 per child – disk)

THIS AUTHORIZATION IS EFFECTIVE FOR (choose one) ☐ 1 year or ☐ _____

TYPE OF RECORDS

☐ Health care information related to the following treatment or condition:_____

☐ All visit notes - please include growth charts and immunization records

☐ **Other (specify):** _____

I understand that:

- I have the right to revoke this authorization at any time;
- in order to revoke this authorization, I must do so in writing and present **my written revocation to Cottonwood Pediatrics Medical Records Release of Information office** at the above address;
- the revocation will not apply to information that has already been released in response to this authorization;
- the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire one year from the date signed, below.

A fee may be charged for preparing, copying and sending records.

I also understand that:

- treatment is not conditioned upon the execution of this authorization;
- if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy;
- regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization.

_____ (DATE) _____ (SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PARTY) _____ (RELATIONSHIP TO PATIENT)